

**Waiver 5 0208 and 1037 Home and Community-Based Services (ages 16 and older)
Freedom of Choice and Consent Form effective 7/1/2013**

Individual's Name: _____

SSN: _____

DOB: _____

The DDP Waiver 5 Freedom of Choice Form is used to ensure that all Developmental Disabilities Program waiver participants understand their right to:

1. Choice of waiver services, including self-direction
2. Choice of providers of DDP funded services
3. Choice of filing a fair hearing request
4. Choice between waiver services and Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID)

Please have the individual or guardian initial each item and sign and date at the bottom.

_____ I have been informed of services available through the Medicaid Home and Community-Based Services Waiver Program. The choice of service provider and choice of services are available to all persons in DDP-funded services subject to demonstration of assessed need.

_____ I have been informed of the conditions under which I may choose to self-direct my waiver services.

_____ I have been informed that if my assessed needs cannot be adequately and safely met in the community, I will not be offered DDP-funded services. I have also been informed that if while in DDP-funded services my condition deteriorates to the point that I cannot be maintained safely in the community, I could be subject to placement in a more restrictive setting such as an ICF/IID.

_____ I have been informed of services available in an ICF/IID facility, including the judicial process involved in the placement of persons in an ICF/IID facility.

_____ I have been informed that I have the right to request a Montana Department of Justice criminal back ground check at no personal cost to me for any person providing me with services not under contract with the DDP. I understand that employees of agencies under contract with the DDP are required to have background checks.

_____ I have been informed of the State of Montana fair hearing process if I am denied the service(s) of choice or the provider(s) of choice.

After reviewing my options and choices, I freely choose to (*check all that apply*):

☐ Receive services in the community via the HCBS DD Medicaid Waiver.

☐ Receive services from my existing provider(s). _____

☐ Receive services from a different provider (specify). _____

☐ Self direct allowable waiver services.

☐ Not receive DDP-funded waiver services at this time.

Individual/Guardian or Personal Representative

Date

Targeted CM or Waiver Children's Case Manager (WCCM)

Date

Department Representative – for initial Waiver 5

Date